DATE OF REVIEW: April 23, 2010

IRO Case #:

Description of the services in dispute:

Retrospective request - Left elbow cubital tunnel release.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer is a member of the American Academy of Orthopaedic Surgeons, the Arthroscopy Association of North America and the American Shoulder and Elbow Association. This reviewer has been in active practice since 2000.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Medical necessity does exist for the requested left elbow cubital tunnel release.

Information provided to the IRO for review

Records Received From The State:

Fax from Texas Department of Insurance, 4/5/10, 1 page
Confirmation of receipt of request for an IRO, 4/5/10, 6 pages
Notice of case assignment, 4/25/10, 1 page
Request for IRO, 3/31/10, 2 pages
Letter 3/30/10, 1 page
Notice of utilization review findings, 3/30/10, 3 pages
Notice of utilization review findings, 3/12/10, 3 pages
Letter 3/12/10, 1 page

Records Received From Texas Attorney General:

Letter, 4/5/10, 1 page
Index, undated, 2 pages
Notice of employee's work related injury/illness, xx/xx/xx, 1 page
Diagnostic coversheet, undated, 1 page
Radiology report, 6/16/04, 1 page
CT report, 6/16/04, 1 page
X-ray report, 6/16/04, 3 pages
MRI report, 6/17/04, 2 pages
Imaging report, 6/29/04, 4 pages
Imaging report, 7/21/04, 1 page
Imaging report, 8/6/04, 2 pages
Electrodiagnostic report, 8/24/04, 12 pages
Patient note, 8/25/04, 1 page
Imaging report, 8/6/04, 2 pages
Imaging report, 6/20/04, 2 pages
Assignment of benefits form, 8/24/04, 1 page
MR report, 11/9/04, 2 pages
Diagnostic radiology report, 2/7/05, 2 pages
Diagnostic radiology report, 3/17/05, 2 pages
Diagnostic radiology report, 3/21/05, 2 pages
Imaging report, 7/28/05, 4 pages
Functional capacity evaluation, 1/22/09, 5 page
Electrodiagnostic report, 11/10/09, 2 pages
Medical documentation coversheet, undated, 1 page
Patient notes, 6/16/04-6/17/04, 1 page
Emergency room note, 6/16/04, 4 pages
Continuation form, 6/16/04, 1 page
Notes, 6/16/04-6/17/04
Office note, 6/24/04
PT evaluation, 6/28/04, 1 page
Imaging report, 6/29/042 pages
Therapy notes, 6/30/04-7/12/04
Note, 7/8/04
Therapy notes, 7/14/04-8/20/04, 6 pages
Initial evaluation, 8/9/04, 1 page
Lumbar evaluation, 8/11/04, 1 page
Shoulder evaluation, 8/11/04, 1 page
PT evaluation, 8/11/04, 3 pages
Therapy notes, 8/13/04-9/29/10, 7 pages
PT status report, 9/27/04, 3 pages
Patient notes, 9/24/04-10/15/04, 4 pages

Follow up note, 10/12/04, 2 pages
Patient notes, 10/18/04–11/1/04, 4 pages
PT status report, 11/3/04, 4 pages
Follow up note, 11/22/04, 2 pages
Patient notes, 11/29/04–11/29/04, 3 pages
PT status report, 12/27/04, 4 pages
Patient notes, 1/12/05–1/17/05, 1 page
Operative report, 1/28/05, 3 pages
History and physical/progress record, 1/28/05, 1 page
History and physical, 1/28/05, 2 pages
Operative report, 1/28/05, 2 pages
Patient notes, 1/3/05–1/10/05, 1 page
Postoperative follow up note, 3/17/05, 1 page
Initial evaluation, 4/11/053 pages
Patient notes, 5/11/05–5/23/05, 1 page
PT status report, 5/16/05, 1 page
Patient notes, 5/2/05–5/9/05, 3 pages
Operative report, 6/16/05, 2 pages
Patient notes, 6/8/05–4/26/06, 9 pages
Follow up visit notes, 4/21/06, 3 pages
Notes, 5/10/06–10/11/06, 5 pages
Daily treatment note, 7/18/06–8/21/06, 6 pages
Follow up visit notes, 8/23/06–11/13/08, 15 pages
Health insurance claim form, 12/16/08, 1 page
Letter, LLP, 12/16/08, 3 pages
Letter MD, 1/23/09
Work status report, 12/16/08, 1 page
Functional capacity evaluation, 1/22/09, 5 pages
Follow up note, 3/2/09, 3 pages
Follow up note, 4/6/09, 2 pages
Follow up note, 5/4/09, 3 pages
Follow up note, 7/13/09, 1 page
Procedure note, 7/16/09, 3 pages
Postoperative note, 7/20/09, 2 pages
Patient note, 8/3/09, 1 page
PT initial evaluation, 8/10/09, 3 pages
PT progress note, 8/28/09–9/2/09, 3 pages
Patient note, 9/2/09, 2 pages
PT progress note, 8/10/09–10/12/09, 21 pages
Patient notes, 11/25/09–1/25/09, 5 pages
Letter, LLP, 3/15/10, 4 pages

Evaluations coversheet, undated, 1 page
Report of medical evaluation, 10/10/05, 1 page
Work status report, 10/3/05, 1 page
Letter, LLP, 10/3/05, 4 pages
Report of medical evaluation, 7/5/06, 1 page
Work status report, 7/6/06, 1 page
Letter, LLP, 6/27/06, 5 pages
Report of medical evaluation, 1/18/07, 1 pabe
Invoice, 12/13/06, 1 page
Patient note, 1/18/07, 10 pages

Records Received From Forte:
Fax 4/5/10, 1 page
Notice of assignment of IRO, 4/5/10, 2 pages
Precertification request, 1/29/10, 1 page
Surgery scheduling form, 1/25/10, 2 pages
Follow up note, 1/25/10, 4 pages

Records Received from Ogletree Abbott Law Firm:
Fax, 4/8/10, 2 pages
Work status report, 3/31/10, 1 page
Work status report, 8/17/09, 1 page
Procedure note, 7/16/09, 3 pages
Release form, 7/16/09, 1 page
Patient information, 7/16/09, 1 page
Anesthesia report, 7/16/09, 1 page
ROC ASC implant log, 7/16/09, 1 page
Functional capacity evaluation, 1/22/09, 4 pages
Follow up note, 8/23/06-9/20/06, 4 pages
Therapy prescription, 7/26/06, 1 page
Postoperative visit note, 7/26/06, 2 pages
Therapy prescription, 6/28/06, 1 page
Postoperative visits note, 6/28/06, 2 pages
Therapy prescription, 5/31/06, 1 page
Postoperative visit note, 5/31/06, 2 pages
Surgery scheduling form, 5/25/06, 1 page
Lab report, 4/21/06, 2 pages
Follow up visit note, 4/21/06, 3 pages
New patient visit note, 2/3/06, 2 pages
Neurological consultation, 9/22/04, 2 pages
Patient notes, 6/6/04, 7/9/04, 3 pages

Clinic notes, 6/16/04, 1 page
PT evaluation, 6/28/04, 1 page
Physician orders, 6/19/04, 1 page
Peripheral nerve block record, 7/16/09, 1 page
Letter, 4/8/10, 1 page
Patient notes, 3/31/10, 2 pages
Letter, LLP, 3/15/10, 4 pages
Follow up visit note, 1/25/10, 3 pages
Letter, 10/26/09, 1 page
Patient note, 10/14/09, 2 pages
Prescription, 10/14/09, 1 page
Letter MD, 10/14/09, 2 pages
Postoperative visit, 9/9/09, 2 pages
Letter MD, 9/9/09, 2 pages
Therapy prescription, 7/16/09, 1 page
Prescription, 9/9/09, 1 page
Postoperative visit note, 8/17/092 pages
Letter MD, 8/17/09, 2 pages
Follow up visit note, 5/4/09, 3 pages
Follow up visit note, 4/6/09, 2 pages
Follow up visit note, 3/2/093 pages
Follow up visit note, 2/7/07, 2 pages
Postoperative visit note, 11/1/06, 2 pages
Benefit dispute agreement, 3/22/07, 3 pages
Release form, 3/8/101 page
Hearing notie, 5/21/07, 2 pages
Decision and order form, 5/15/07, 4 pages
Letter, 1/25/10, 1 page
CD, undated

Patient clinical history [summary]

The patient is a male who had a fall in xxx. He had imaging showing advanced spondylosis of the cervical spine, rotator cuff tear, and EMG (electromyogram) showing mild ulnar neuropathy in the left elbow and mild cervical radiculopathy of multiple levels. Patient underwent cervical fusion and shoulder surgery. On 4/16/06, the patient had left ulnar nerve injection for cubital tunnels syndrome. The patient was seen by Dr. on 4/21/06 with complaints consistent with cubital tunnel syndrome. The exam showed numbness in the ulnar distribution with atrophy of the ulnar muscles. On 2/21/07 and 4/4/07, patient complained of ulnar distribution hand numbness. On 12/16/08, Dr. diagnosed cubital tunnel syndrome with visible atrophy of the ulnar innervated muscles of the forearm and hand. Dr. recommended ulnar nerve decompression several times including in January of 2010.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The left elbow cubital tunnel release was medically necessary. The patient has had consistent complaints of ulnar nerve distribution numbness, tingling with exam findings consistent with atrophy of the ulnar innervated muscles of the forearm and hand. This has been consistent throughout his medical care since his injury. There are several doctors who have recommended treatment for this. The patient's atrophy will not return. However, the patient may improve some of the subjective symptoms related to the ulnar nerve compression. He may improve some of the hand function. The patient has had medications, activity modification, injection for the cubital tunnel syndrome. Therefore, there has been adequate conservative care. There is ulnar nerve pathology on EMG and by exam. The surgery is medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Surgery for cubital tunnel syndrome (ulnar nerve entrapment):
Recommended as indicated below (simple decompression). Surgical transposition of the ulnar nerve is not recommended. Surgery for ulnar neuropathy at the elbow is effective two-thirds of the time. The outcomes of simple decompression (SD) and anterior subcutaneous transposition (AST) are equivalent, except for the complication rate, which is 31% in AST. Because the intervention is simpler and associated with fewer complications, SD is advised, even in the presence or (sub)luxation. (Bartels, 2005) (Asamoto, 2005) (Lund, 2006) (Nabhan, 2007) Although clinically equally effective, simple decompression was associated with lower cost than anterior subcutaneous transposition for the treatment of ulnar neuropathy at the elbow. The main difference was in the costs related to sick leave, which is significantly shorter for simple decompression. (Bartels2, 2005) (Nabhan, 2005) Simple decompression may offer excellent intermediate and long-term relief of symptoms. Less complete relief of symptoms following ulnar nerve decompression may be related to unrecognized carpal tunnel syndrome or weight gain. (Nathan, 2005) Medial epicondylectomy for persons with cubital tunnel syndrome was superior to anterior transposition in relieving pain and in improving global outcome scores. Patients whose cubital tunnel syndrome is caused by an acute trauma have better outcomes after surgical treatment than patients with cubital tunnel syndrome from other causes. (AHRQ, 2002) Partial medial epicondylectomy seems to be safe and reliable for treatment of cubital compression neuropathy at the elbow. (Efstathopoulos, 2006) One study reviewed the results of two surgical methods for treating cubital tunnel syndrome. From 1994 to 2001, minimal medial epicondylectomy was performed on 22 elbows, and anterior subcutaneous transposition of the ulnar nerve was done on 34 elbows. In the group treated by medial epicondylectomy, 9 of the results (41%) were excellent, 10 (45%) were good, 2 (9%) were fair, and 1 result (5%) was poor. In the group treated by anterior subcutaneous transposition of ulnar nerve, 14 of the results (41%) were excellent, 13 (38%) were good, 6 (18%) were fair, and 1 result (3%) was poor. No significant difference was found between the 2 groups ($P < .05$). (Baek, 2005) (Greenwald, 2006) Age at surgery, duration of cubital tunnel syndrome, preoperative severity, and clinical

symptom score and motor nerve conduction velocity in the early postoperative stage (one month after surgery) were found to be important prognostic factors of the syndrome. (Yamamoto, 2006)

ODG Indications for Surgery -- Simple Decompression (SD) for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:

- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonically within 0-45 degrees

- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma.

- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.

- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.